

Registration District No. **153**

Primary Registration District No. **5217-4087**

Registrar's No. **4**

FILED MAR 14 1940

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I. PLACE OF DEATH:
(a) County Cass
(b) City or town Freeman
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Jimmie Warner
3. (b) If veteran, name war _____ **3. (c) Social Security No.** _____

4. Sex Female **5. Color or race** white
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife William Warner **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased June 24 1867
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 3
If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Missouri (State or foreign country)
10. Usual occupation House keeper

11. Industry or business _____
MOTHER FATHER
12. Name John Duncan
13. Birthplace _____ (City, town, or county) Mo. (State or foreign country)
14. Maiden name Jessie Shaler
15. Birthplace _____ (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Clive Van Meter
(b) Address Freeman Mo.
17. (a) Burial **(b) Date thereof March 1
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Freeman Mo.
18. (a) Signature of funeral director Geo. E. Myers
(b) Address Cleveland Mo.
19. (a) 2-29-40 **(b) Mrs. Pearl Sudduth**
(Date received local registrar) (Registrar's signature)**

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Cass
(c) City or town Freeman
(If outside city or town limits, write "RURAL")
(d) Street No. S
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 27
year 1940 hour 12 minute ✓ M.
21. I hereby certify that I attended the deceased from Jan 20 - 1940 to Feb 27 1940
that I last saw her alive on Feb 10 - 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis with Myocard Regeneration
Due to _____
Due to _____
Other conditions Serility
(Include pregnancy within 3 months of death)
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 14th
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature J. H. Scott (M. D. or other) _____
Address Harlemville Mo **Date signed** Feb 28 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Geo. E. Myers

Licensed Embalmer No. 2377

P. O. Address Cleveland Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6240
Registrar's No. 4

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 153

Primary Registration District No. 4087

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Cass
(b) City or town Freeman
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jimmie Warner
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased June 24 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 3 If less than one day _____ hr _____ min

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-29-1940 (b) Mrs Beal Suddarth
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

20. DATE OF DEATH: Month Feb day 27 year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature J. N. Scott (M. D. or other) _____
Address Warrensburg Date signed _____

SUPPLEMENTAL ENTRY

